Be Your Best – Medical Clearance Form

Be Your Best is a 10 month program aimed at reducing risk of type 2 diabetes and cardiovascular disease through weight loss, diet changes, and physical activity. This program is offered through the Missoula City-County Health Department and is led by a registered dietitian and group exercise specialist to help ensure individual success.
Please complete this form in its entirety and fax to 258- 4906, Attn: Heather Sauro, MS, RD.

Patient Name: _____ **Date of Birth:** _____ ❑ **Female** ❑ **Male**

Medical eligibility
(All of the following must be checked in order to be medically eligible)

- ❑ BMI >25 Ht: _____ Wt: _____ BMI: _____
- ❑ 18 years or older
- ❑ No diagnosis of type 2 diabetes or unstable cardiac disease
- ❑ Able to participate in moderate physical activity, ≥ 150 mins/week
- ❑ Able to understand and participate in lifestyle intervention including detailed food journaling
- ❑ Expresses readiness to consider changing diet and physical activity
- ❑ No severe mental health diagnosis or alcohol/substance abuse that would affect successful participation (by provider judgment)
- ❑ For women: more than 6 months post-partum, not pregnant, or planning pregnancy in the next year

Patient has following risk factors ***(Please check all that apply. Patients need AT LEAST ONE other risk factor for eligibility)***

- ❑ History of Gestational Diabetes
- ❑ Baby > 9 pounds birth weight
- ❑ Current Pre-Diabetes (impaired Fasting Blood Glucose = 100-125)
  - ❑ On Metformin
- ❑ Hypertension ***(BP > 130/85)***
  - ❑ On Medication
- ❑ Dyslipidemia (***TG > 150mg/dl; LDL > 130mg/dl; HDL < 50 (women), HDL < 40 (men))***
  - ❑ On Medication

Patient Contact Information:

_____
Name

_____
Phone

_____
Street Address

_____
City /State/ Zip

Patient Labs
(Blood pressure, fasting glucose and fasting lipid panel within the past 6 months ARE REQUIRED. HbA1C is recommended, but optional. The results can be attached or entered below. Please include both normal and abnormal results.)

- ❑ Blood Pressure: _____ Date: _____
- ❑ Fasting Blood Glucose: _____ Date: _____
- ❑ HgbA1C *(optional)*: _____ Date: _____
- ❑ Total Cholesterol: _____ Date: _____
- ❑ Triglycerides: _____ Date: _____
- ❑ HDL Cholesterol: _____ Date: _____
- ❑ LDL Cholesterol: _____ Date: _____

_____ _____
Physician /Provider name Affiliation

_____ _____
Physician /Provider Signature Date

It's good Public Health.
Missoula City-County Health Department
Missoula, MT 59802

Be Your Best Diabetes Prevention Program
Heather Sauro, MS, RD, Lifestyle Coach
P : 406-258-4935 F: 406-258-4906